"Enhancing Care in the Dialysis Setting: Motivation, Communication, and Simulation"

Module 4: Why We Do What We Do: Leadership and Motivation in the Dialysis Setting

Introduction

Several books, research articles, commentaries and other writings have attempted to define leadership and quantify its role in society and more specifically, in the workplace. Some have taken a highly scientific tone while others have been personal accounts of what leadership may mean on an individual level. In the healthcare field, and dialysis in particular, assessing what leadership is and quantifying the value of it is not an easy task. In addition, determining any kind of practical applications of leadership in the dialysis workplace – in end stage renal disease (ESRD), for example – remains a complex, yet useful endeavor. As clinicians it is important to understand leadership since understanding others' behavior as well as our own within the context of leaders and followers has the potential to improve outcomes in dialysis.[1]

Similarly, what is motivation? In most cases, it is clear that motivation and leadership are intertwined, but how do we put a finger on what motivates us as individual clinicians and what motivates a group of individuals in the dialysis setting? It is also clear that some people are more motivated than others, though it is sometimes difficult to determine why one person possesses a high level of motivation while another individual does not. In this article, we will aim to define leadership and motivation with regard to the dialysis setting, and take an internal look at what drives us toward success in the workplace.

What is a Leader? What is a Follower?

To start, we must make an effort to discern between a leader and a follower. In short, most of us are both leaders and followers. We assume these roles somewhat naturally – in the office, the dialysis clinic, the ESRD network facility, the operating room, and elsewhere. We assume the leader or follower role based on our current mindset, inherent personality traits and the specific circumstances in which we are operating. Similar to a classroom setting where the teacher is the leader and the students are followers, clinicians such as physicians and nurses take on a leadership role in the clinical setting while patients naturally fit into the follower role.

Of course, to provide the optimal care for patients in the clinical workplace, leaders must take on the responsibility of demonstrating leadership qualities.[1] Table 1 below illustrates several traits commonly seen in effective leaders and several traits that ineffective leaders demonstrate as well. Not every great leader has all of the attributes associated with effective leaders. However, this table provides several insights to potentially make ourselves and our dialysis teams more effective from a leadership standpoint.

Table 1: Characteristics of Effective and Ineffective Leaders[1]

Effective Leader Qualities	Ineffective Leader Qualities
Knowledgeable	*Arrogant*
Personable	*Insecure*
Nice, yet firm	*No rules*

Knows when to draw the line	*Moody*
Engaging personality	*Quick temper*
Interdependent (team) thinking	*Blames others*
Service above self	*Selective in giving support*
Trustworthy	*Shows favoritism*
Good listener	*Self-centered*
Good sense of humor	*Dishonest*
Goes the extra mile	*Loud and dominating*
Does not dictate	*Poor listener*

While someone may make conscious attempts to improve their leadership and sway themselves toward the left hand side of Table 1, many of the traits we show as individuals were hard-wired into our brains at birth. Daniel Goleman has studied some of these traits.[2-3] When people interact with each other, various processes occur in the brain, and Goleman has demonstrated that there are actual brain cells that may help define effective and ineffective leaders. For example, mirror cells fire based on leaders' emotions and actions, and subsequently prompt followers to mirror those feelings, a phenomenon that may address why delivery often is more important than the content of the message itself.[1] Further, spindle cells fire when choosing the correct response from various possibilities, and they form the basis for gauging whether or not a person can be trusted. They fire very quickly – within milliseconds – and offer us insight into how we feel about someone. In other words, these are our snap judgements.[1] In essence, leadership has foundations in both learned personality traits and the complex interactivity of various cells and connections within our brain.

Motivation in the Workplace

In a previous piece, we discussed motivation – what causes us to do what we do, and why. In this context, our internal motivations are grounded significantly within our ability to be effective leaders. In clinical practice, it is important to ask questions such as what drives us, how and to what extent we are motivated to do well in the workplace, how important profit motive is in our jobs, and why we do anything at all. To answer these questions, we need to look at our own motivations and address these questions on an individual basis since the answers have implications in how and why we provide care to our patients.

In the dialysis setting, whether you're a leader or not is based on your internal drive. The characteristics in Table 1 are grounded in our own individual personalities, but there is always the potential to hone your skills and work toward becoming a better leader. So the question arises - what are the different types of motivation for choosing a particular field? In his book, "Drive: The Surprising Truth About What Motivates Us," Daniel pink sets forth three basic types of motivation, each of which affects our clinical decision-making differently.[4] These three are outlined as follows:

- Motivation 1.0: The motivation to survive.
  Motivation 2.0: Reward or punishment (extrinsic, such as money, power, status).
- Motivation 3.0: Reward based on autonomy, mastery, and purpose (intrinsic).

Motivation for various aspects of care can also be based on Maslow's motivational hierarchy, which includes elements of physiology, safety, belongingness, self-actualization, and others.[5] Each of these items may be applied to the medical field. For example, many of us entered into the medical field not only because of our desire to heal the sick, but because of the challenge of the field itself. In this regard, we are pursuing self-actualization, or realization of our full potential. Further, as our knowledge and

experience as clinicians continues to expand in our respective fields, our own self-actualization continues to be reinforced at the same time. Ultimately we, as clinicians, could benefit strongly from evaluating our own motivations for success in the workplace, and assessing the role of these motivations as they relate to leadership qualities. From there, we can optimize our individual and team-based standards of care to help improve patient outcomes.

Fostering Leadership and Motivation in the Clinical Setting

In the workplace, doing a better job and getting an extrinsic reward in return (money, better job, etc.) seems like a logical idea. In fact, in many cases, these actually represent the precise motivations for why someone chooses their particular profession. However, these particular motivations are a much weaker foundation for breeding leadership than those of autonomy, self-actualization, genuine care for people, and other higher-level motivations. Indeed, when pressured to perform for an increase in pay or a promotion, creativity suffers, and clinical outcomes can be negatively affected. Interestingly, clinicians who face the greatest challenges are typically those who focus on financial or tangible goals. They are often likely to demonstrate ineffective leadership skills such as insecurity and selfishness as well. Facing challenges, problem solving, collaboration, empathy – these are some of the higher order motivations that foster leadership.

Another item to mention is competition. In some institutions – pharmaceutical sales for example – the culture is one that thrives on competition. Who makes the most sales rather than who satisfies the customer most effectively is the order of the day. However, the opposite should be true for clinicians in dialysis. We should be much more focused on aspects of care – teamwork, empathy, etc., – that provide patients with improved service.

In the dialysis setting, a center that encourages leadership has the faculties to judge and manage the culture and values of the institution. A system in which its members engage mostly in self-interest is doomed to fail while institutions with support systems at work (both up and down in a hierarchy) are more likely to succeed. Similarly, institutions which have programs for personal development, (e.g., mentoring and feedback where key individuals offer time and knowledge for the purpose of professional development) are, through no coincidence, the same ones that have strong medical and community leaders.[1] At these centers, team members are inspired, mission statements are understood and pursued, and the best personnel are placed into positions where they are most likely to succeed and derive satisfaction from it. The dialysis center with strong leaders will have staff members that are proud of their company and proud of each other. They'll work as a team, share responsibility, and empathize with one another.[1] The success of this type of center starts from the top down. The management, who are already in positions of leadership, is responsible for facilitating an environment in which further leadership is encouraged, and members of the team are inspired to improve themselves and their standards of dialysis care.

Conclusion

In the field of dialysis, it is important to understand what leadership is and how best to pursue it in the clinical setting. Through gaining an understanding of our own ability as leaders, we will also come to understand each other's behavior, and from there we can enhance teamwork and patient outcomes as a whole.[1] Understanding our motivations for everything from why we chose our particular field to why we desire to offer a specific treatment to a patient is also grounded in leadership, and once we quantify our own occupational motivations, we'll be more fully able to assume a leadership role on our respective dialysis teams.

References

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